Chapter 2 - Payment Method

Federal law requires that states use published payment methodologies and justifications which specify comprehensively the methods and standards for making Medicaid provider payments to long term care facilities.

2-1 Assurance of Payment

Certified Title XIX Long Term Care Facilities furnishing services in accordance with all state and federal Medicaid laws and rules will be paid in accordance with rates established under the state Medicaid plan.

2-2 Acceptance of Payment

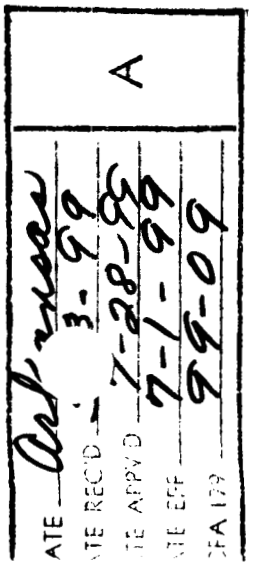
Participation in the Title XIX Program is limited to those Facilities which agree to accept the Medicaid payment as payment in full for all care services provided to Medicaid recipients.

2-3 Upper Limits based on Customary Charges

In no case may the reimbursement rate for services provided under this plan exceed an individual facility's customary charges to other third party payers for such services, except for those public facilities rendering such services free of charge or at a nominal charge.

A facility will be given a period of 60 days after notification of a Medicaid rate increase to implement any required increase to other residents. If the Medicaid increase is effective retroactively, the facility will not be required to collect increases retroactively from other residents.

2-4 Facility Class



The Department has established the following specific payment methods:

A. Nursing Facilities

1. Reimbursement Methodology

Reimbursement rates for NF providers will be implemented on a prospective uniform class per diem rate system by resident level of care. An inflationary factor, determined by the Division to be reasonable and

SUPERSEDES: TN - 90-1

adequate, will be applied to the existing rates by level of care and will be implemented by state plan amendment annually. Reimbursement rates for NF are implemented effective the first day of the state fiscal year.

2. Current Fiscal Year NF Reimbursement Rates

It has been determined by analysis of financial and statistical data that an increase of 3.25% to the existing per diem rates (established for the period July 1, 1996 - June 30, 1997) is reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws and regulations including those costs of services required to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The 3.25% rate increase is for inflation based on the HCFA Market Basket forecast for Nursing Facilities. Current rates established July 1, 1997 through June 30, 1998 will be as follows:

Nursing Facilities: Skilled - $75.58
Int. I - $75.58
Int. II - $62.84
Int. III - 58.42

3. Rate Changes and Payment Adjustments

a. Since July 1, 1981, SNFs and ICFs, referred to as NFs as of October 1, 1990, have been reimbursed under a prospective class rate system. Inasmuch as the nature of prospective class rates precludes individual facility rate adjustments, the interim rates established for Nursing Facilities shall not be changed as a result of increases in bed capacity, changes in ownership, or adjustments to the calendar year cost reports resulting from provider corrections, desk reviews or audits. However, audit findings processed administratively by the Division, may be considered in determination of rates for subsequent rate periods.

b. Changes in a facility's licensed classification shall result in a change to the appropriate uniform rates for the new classification, retroactive to the facility's date of Medicaid certification for the new class.

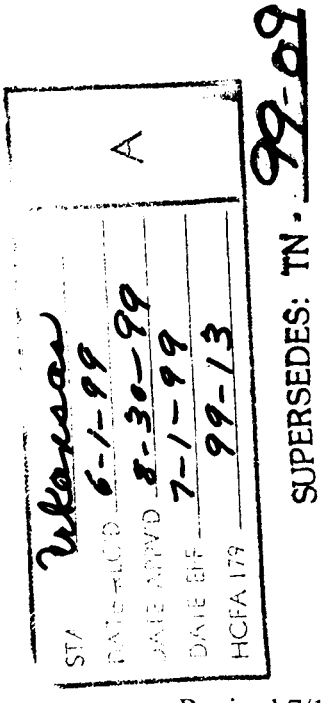
c. Overpayments/underpayments resulting from administrative error situations on the part of the Division or on the part of facilities, as described in Section 1-12 of this Program Manual, will be corrected when discovered.

d. All of the costs of compliance with the Omnibus Budget Reconciliation Act (OBRA) of 1987 appear in provider cost reports.

4. Wage Enhancement Program

a. Reimbursement Methodology

In accordance with Section 127 of Act 1537 of the 1999 82nd General Assembly Regular Session, and effective for dates of service beginning July 1, 1999, the Arkansas Department of Human Services will reimburse an additional enhancement amount per Medicaid reimbursed patient day to Medicaid certified nursing facilities (not including Benton Services Center) that meet Office of Long Term Care minimum staffing requirements as set forth below. Minimum staffing requirements are identified as those requirements which are in effect by rule and are recorded in the Medicaid Long Term Care Provider Manual for the last day of each previous quarter. The enhancement amount is necessary in order to increase current staffing levels, improve recruitment and retention of staff and improve the quality of direct care personnel. The per diem enhancement amount will not be made as a separate payment but will be added to the current class per diem rates by level of care unless being withheld as described in subsection c. below. Beginning July 1, 1999, the enhancement amount will be $4.93 per Medicaid reimbursement patient day. The $4.93 was calculated based on the lessor of available funding or projected increased cost associated with the wage enhancement package, divided by the projected number of Medicaid resident days. Funded appropriation is identified in appropriation 897-77. The projected increase in additional staffing cost was determined by adding the projected increase in certified nurse aide hours multiplied by the estimated average hourly wage for certified nurse aides. The balance of the wage enhancement add-on to be used to improve recruitment and retention of staff and improve the quality of direct care personnel is projected as the difference in additional staffing and the $4.93 per day add-on. As also required in Section 127 of Act 1537, the per diem enhancement amount will be reviewed by the department prior to the beginning of SFY 2001. Based on the review and the certification of the Chief Fiscal Officer of the availability of additional general revenue allocations provided for the wage enhancement program as identified in Section 127 and the availability of federal financial participation, a revised enhancement amount may be implemented as of July 1, 2000, using the methodology described above. If the wage enhancement amount is revised, a plan amendment will



be submitted prior to implementation of the rate change effective July 1, 2000.

b. Quarterly Staffing Reports

Medicaid certified nursing facilities will be required to submit to the Department quarterly staffing reports, which will be reviewed to determine compliance with the minimum staffing requirements as enhanced pursuant to Act 1529 of 1999. The Department may also perform periodic on-site reviews, which may be unannounced, in order to determine the correctness and completeness of the submitted quarterly reports.

Quarterly reporting periods will follow the State Fiscal Year and have ending dates as of September 30th, December 31st, March 31st and June 30th. The quarterly reports must be filed with the Division of Medical Services or postmarked on or before 30 days following the last day of the reporting quarter. Should the due date fall on a Saturday, Sunday, State of Arkansas holiday or federal holiday, the due date shall be the following business day. Failure to submit a quarterly report when due can result in the withholding of the enhancement amount in the following quarter or quarters until the report is received and can also result in the assessment of a Class C violation and penalty under Arkansas Code 20-10-205 and 20-10-206.

If a facility changes ownership during a reporting quarter, all owners are required to submit a quarterly report for the days occurring during their ownership. If an ownership change occurs, all reimbursement to the owner who sold the facility will be withheld after the last day of ownership until the quarterly report has been submitted and reviewed. Failure to submit this final quarterly report can also result in the assessment of a Class C violation and penalty under Arkansas Code 20-10-205 and 20-10-206.

The quarterly staffing reports and related information should be mailed to:

Arkansas Department of Human Services
Division of Medical Services, Provider Reimbursement
P.O. Box 1437, Slot 1104
Little Rock, AR 72203-1437

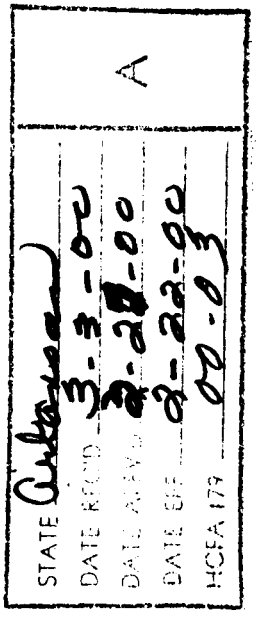
Staff hours and payroll information (salaries, State and Federal payroll reports and supporting documents, contract employee

services) will be reported on the quarterly staffing report. Only those hours spent performing direct care employee class (CNA, RN, LPN, Director of Nursing) related duties will be allowable in the determination of meeting the minimum staffing requirements. RN, LPN and LVN hours and cost information can also be included in the staffing requirements for certified nurse assistant if associated with performing nurse assistant duties but these hours and costs must be identified separately on the quarterly staffing report. RN's can also be used to perform LPN duties with the same reporting requirements. Resident daily census by level of care for the reporting period will also be included in the quarterly report. Adequate documentation must be retained by the facility to support all information identified in the submitted quarterly staffing reports.

c. Failure To Meet Staffing Requirements

Failure to meet the minimum staffing requirements as enhanced pursuant to Act 1529 of 1999 in a reporting quarter will result in the repayment by the facility of 100% of the enhancement payments received for dates of service occurring in the corresponding reporting quarter. Providers will be notified by the Division of Medical Services of the amount which must be repaid. Providers will be given thirty (30) days to reimburse the Department.

For purposes of this provision, "failure" means that the facility did not have all required staff present and performing assigned duties for the entire time required each shift. Failure does not include those instances where staff report to work within two hours of the shift beginning time and work an entire shift amount of time. When this occurs, the time worked into the following shift is counted toward the first shift's staffing requirements and is not included when determining the following shift's staffing requirements. No facility will be deemed to have failed to meet staffing requirements for only minor and isolated staffing shortage occurrences. A staffing shortage occurrence means that no employee/contract employee was present to fill a staff position within two hours of the shift's beginning time or the employee/contract employee did not complete the shift. Effective for reporting quarters ending March 31, 2000 and after, minor and isolated means that staffing shortage occurrences for CNA's and the combination of RN's and LPN's do not occur more than the number of times per quarter identified below per number of patients. The number of patients is the daily average number of



SUPERSEDES: TN - 99-13

patients in the facility as calculated from the daily census for the reporting quarter. This is calculated by dividing the total number of patient days reported for the quarter by the total number of days reported in the quarter

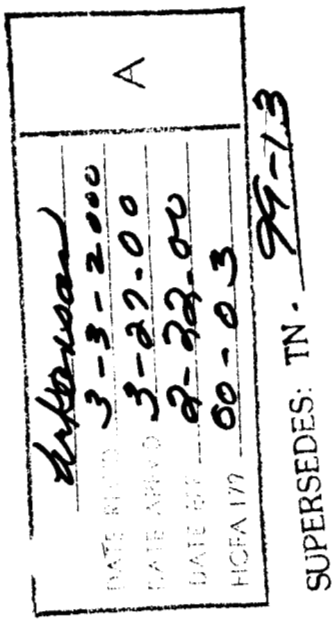
Number of Patients	CNA	RN/LPN
0 – 100	45	12
101 – 150	48	15
151 – 200	54	18
201 & Above	60	21

Special exemptions to the staffing requirements may be granted by the Department when staffing shortages occur due to natural disasters and labor strikes. Supporting documentation must be submitted with the quarterly report if a facility requests a special exemption for these identified reasons.

Failure to meet the minimum staffing requirements for two consecutive quarters will result in the immediate suspension and withholding of the enhancement amounts in the following quarter. Any withheld enhancement amounts for a quarter can be reimbursed after the quarter has ended if the facility's reviewed quarterly report reflects that the facility met the minimum staffing requirements during that quarter. Thereafter, enhancement payments will resume normally.

d. Appeals

See Section 1-10 concerning the applicable appeals process.



B. Intermediate Care Facilities for the Mentally Retarded

1. 16 Bed & Over - State-Operated Facilities:

Effective January 1, 1994, the method of reimbursement for ICF/MR state-operated facilities certified as having more than 15 beds will be based on actual cost with provisions for retrospective adjustment semi-annually to ensure reimbursement of actual allowable, reasonable costs. Each facility will have an interim per diem rate established based on the most recent semi-annual cost report. This interim per diem rate will be adjusted retrospectively as a result of actual costs for that semi-annual cost reporting period. Rates established for this facility type shall be changed due to adjustments to the semi-annual cost reports resulting from provider corrections, desk reviews, or audits and will be retrospectively adjusted to the first day of the applicable cost report period. The reimbursement methodology for this type facility will be adjusted by submission of a State Plan amendment as warranted.

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DATE EFF 7-1-99
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SUPERSEDES TN - New Page

B. Intermediate Care Facilities for the Mentally Retarded - Continued

2. 16 Bed & Over - Private Facilities:

a. Reimbursement Methodology

Effective with dates of service on or after Janauary 1, 1999, ICF/MR 16 bed and over facilities will be paid a prospective rate based on a combination of actual allowable cost for Direct Care & Care Related costs and a class rate up to a ceiling for Administrative and Operating costs. Effective the beginning of each state fiscal year, rates will be rebased or adjusted for inflation. The Department will in its sole discretion determine whether to rebase the rate or apply an inflationary adjustment.

b. Cost Categories

For rate setting, facility allowable costs from desk reviewed facility cost reports for an annual period determined by the Department, will be identified and grouped as Direct Care & Care Related or Administrative and Operating. Direct Care & Care Related include those expenses the facility incurs in providing care directly to the resident. Because these costs most directly affect the quality of care given a resident, the methodology includes as a component the actual allowable cost incurred for Direct Care & Care Related costs.

Administrative and Operating constitute the remainder of facility costs. Costs associated with Administrative and Operating are more directly controllable by the facility. The methodology includes as a component a class rate up to a ceiling to cover the costs for Administrative and Operating.

For rates effective January 1, 1999, desk reviewed facility cost reports for the period 1/1/97 through 6/30/97 and 71/97 through 12/31/97 were combined to establish the base year rates. Rebasing and cost reporting period for rebasing will be at the discretion of the Department. Should the Department decide to rebase, the most currently available desk reviewed cost reports will be used.

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c. Rate Setting

Rates will be established in the following manner: An average per diem cost for Administrative and Operating will be calculated for the facility class. This will be accomplished by determining per diem cost for Administration & Operating for each facility by dividing the actual allowable cost for each facility by their total resident days, adding the individual facility per diem costs and dividing by the number of facilities within the facility class. A ceiling for Administrative and Operating will be set at 105% of the average. A facility will be paid at the lesser of the ceiling or their actual per diem cost plus 10% of the amount calculated as 105% of the average. A per diem cost will be calculated for each facility for Direct Care and Care Related costs. The per diem cost will be calculated by dividing the actual allowable cost for each facility by their total resident days. A facility's per diem cost for Direct Care and Care Related cost and Administrative & Operating cost will be combined to get a facility's total per diem. Once the total per diem by facility has been established, these rates will be adjusted for inflation from the base year to the rate year. In years that the rates are not rebased, existing rates will be adjusted for projected inflation. The Department will use the HCFA Input Price Index (market basket) – Nursing Facilities published quarterly for determining appropriate inflation rates. Facility rates will be rebased periodically at the Department's discretion.

d. Rate Justification

Modeling of this methodology produced estimates that each facility identified as efficient and economic (providers operating at or below the median of arrayed non-direct care costs) would receive payment equaling 100% (plus or minus 5%) of that facility's actual allowable cost. Cost coverage in the aggregate is equal to or less than 100% for ICF/MR facilities.

STATE Arkansas
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SUPERSEDES: TN - New Page

B. Intermediate Care Facilities for the Mentally Retarded – Continued

3. Under 16 Beds:

a. Small ICF/MR facilities certified as having 15 beds or fewer will be reimbursed on a prospective uniform class rate system. An inflationary adjustment, determined by the Division to be reasonable and adequate, will be applied to the existing rates and will be implemented by State Plan amendment as warranted by analysis of cost report data. Cost reports will be submitted annually for the preceding calendar year (January 1 – December 31) and will be reviewed prior to establishing new rates. The Division has established the per diem rate of $152.23 effective July 1, 2000. This 3% increase in per diem rate is based on the HCFA Market Basket forecast for nursing home index as an inflation factor.

b. Overpayment/Underpayments

Overpayment/underpayments resulting from Section 1-12 administrative errors shall be handled through the vendor payment by recouping overpayments and reimbursing underpayments.

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